SUPERIOR COURT OF NEW JERSEY
LAW DIVISION, CRIMINAL PART
BERGEN COUNTY, NEW JERSEY
INDICTMENT NO. 18-05-00083-S
APP. DIV. NO.

STATE OF NEW JERSEY,	)
	) TRANSCRIPT
vs.	) of
	)
TERRY RAMNANAN,	) MOTIONS DECISIONS
	)
Defendant.	)

Place: Bergen County Superior Court
Justice Center, 10 Main St.
Hackensack, N.J. 07601

Date: May 23, 2019

BEFORE:

HONORABLE ROBERT M. VINCI, J.S.C.

TRANSCRIPT ORDERED BY:

WILLIAM S. WONG, ESQ. (Attorney at Law)

APPEARANCES:

CRYSTAL CALLAHAN, ESQ. (Deputy Attorney General, Appearing for Robert Grady, Esq., Deputy Attorney General)
Attorney for the State

WILLIAM S. WONG, ESQ. (Attorney at Law)
Attorney for the Defendant

Transcriber Dolores Hastings, AD/T 417
APPEALING TRANSCRIPTS INC.
8 Victoria Drive
Clark, New Jersey 07066
(732) 680-1610 / Fax (732) 680-1615
Dolores.hastings@appealingtrans.com
Digitally Recorded
Operator, Bernard Rodrigues

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THE COURT: On the record. All right, State versus Terry Ramnanan, it's -- it's Indictment 18-05-83-S.
Counsel, appearances please?
MS. CALLAHAN: Good afternoon, Your Honor, Deputy Attorney General Crystal Callahan appearing on behalf of Robert Grady on behalf of the State.
THE COURT: Good afternoon.
MR. WONG: Good afternoon, Your Honor, William Wong on behalf of Dr. Terry Ramnanan who's present.
THE COURT: Good afternoon.
DR. RAMNANAN: Good afternoon.
THE COURT: Good to see you and I assume Mr. Grady had a jury duty?
MS. CALLAHAN: Jury duty.
THE COURT: Okay.
MS. CALLAHAN: That's correct.
THE COURT: Okay. Well, thanks for coming in his place, so that we can --
MS. CALLAHAN: Of course.
THE COURT: -- we can do this. Everybody can have a seat. Is any -- is there anything anybody wants to talk to about before --
MS. CALLAHAN: I think there's one

outstanding --
THE COURT: -- before I give you my decision?
MS. CALLAHAN: -- discovery issue per detec -- D.A.G. Grady, and so this is the best efforts of my office to comply with the request from Mr. Wong, so I'm giving these over. These are the transcripts and the recorded statements with respect to some of the other questions, at least as D.A.G. Grady has relayed them to me, the other items do not exist.
MR. WONG: Well, the other item has --
THE COURT: Let's -- let's -- we'll deal with that after.
MS. CALLAHAN: Okay.
THE COURT: Let's deal with that after.
Okay. So this is -- there are two motions that I'm dealing with right here. First is the defendant's motion to dismiss. We also have the defendant's motion to sever.
I'm going to stick to the motion to dismiss first. The -- in terms of the procedural history, I have the defendant's moving brief filed January 25, 2019, I have the State's opposition filed on February 11, 2019, defendant's reply briefs filed on February 19, 2019 and February 20, 2019, the State's re -- reply to those briefs dated -- dated -- dated April 23, 2019,

and the defendant's reply to that brief, which was filed on May 1, 2019. I -- I heard oral argument on this case in connection with these motions on May 13, 2019 and I -- and I asked you to come back -- asked the parties to come back today so I could give you a decision on the motion.

The facts of the case -- around August 1, 2017 defendant was initially indicted for conspiracy in the third degree, commercial bribery and breach of duty to act disinterestly -- disinterestedly in the third degree, and criminal use of runners in the third degree. All of these counts related only to the defendant's allegedly kickback payments to chiropractor Ronald Hayek.

On May 31, 2018 defendant was charged a superseding indictment that included 10 counts and the first -- the first six counts relating to chiropractor Hayek, including conspiracy in the second degree, misconduct by a corporate official in the second degree, healthcare claims fraud in the second degree, theft by deception in the second degree, commercial bribery and breach of duty to act disinter -- disinterestedly in the third degree, and criminal running in the third degree. Then he was also indicted with respect to alleged kickback payments to a second

chiropractor, Dr. Awari, and then -- then those counts included conspiracy in the second degree, healthcare claims fraud in the second degree, commercial bribery and breach of duty to act disinterestedly in the third degree, and commercial running in the third degree.

As I said, Counts 1 and 3, 4, 6 -- 5, and 6 relate to the alleged kickback payments to Arnold Hayek and Counts 7 through 10 relate to defendant's alleged kickback payments to Adam Awari. The misconduct by a corporate official charge, Count 2, is the only count that arises out of the defendant's alleged kickback payments to both Hayek and Awari.

The facts of the case - on May 31, 2018 the State presented evidence to the State Grand Jury to support the following allegations: between January 1, 2012 and April 8, 2016 the defendant, a neurologist using Interventional Spine and Pain Treatment Center, a New Jersey corporation owned by defendant, submitted insurance claims to at least 15 insurance companies based on referrals from chiropractors Hayek and Awari. The State alleges that the defendant paid kickback -- had kickback arrangements with Hayek and Awari under which defendant paid the chiropractors cash bribes for the referral of patients to the Spine and Pain Treatment Center.

After providing the medical procedures, the spine -- the inter -- the Spine and Pain Treatment Center and/or defendant submitted standardized health insurance claim forms to the various insurance companies using a standard health insurance claim -- claim form.

The procedures included patient consultations, needle E.M.G. and nerve conduction tests, and, importantly, the State concedes that the procedures were medically necessary and they were actually performed by qualified medical professionals on legitimate patients. There were no fraudulent claims, there was no over-billing or overcharging. All of the amounts paid by the insurers were for medical procedures needed by -- needed by and performed on their insureds, amounts that the insurance companies were obligated to pay pursuant to the terms of their respective insurance contracts.

The State alleges that the defendant paid Dr. Hayek a total of $25,900 for 196 patients and that defendant paid Dr. Awari approximately $3,000 in referral fees. The State does not allege defendant made any false, fictitious, fraudulent, or misleading statements in the health insurance claims forms, nor does the State allege that the defendant omitted any

information that was requested on those claim forms. The sole allegation is that defendant paid referral fees to Hayek and Awari and did -- did not disclose the alleged payments when he submitted the claim forms. Specifically, the State alleges -- alleged before the grand jury that defendant submitted the claim forms,

"to the different insurance companies, knowing that he or his staff was making misrepresentations or omissions on those forms by omitting to tell the insurance companies that he was breaking an implied certification that he, as a licensed doctor, was on -- or that as a licensed doctor was honoring his fiduciary duty to his patients to not be paying kickbacks to other referral -- referring medical practitioners, and by committing crimes and breaking regulatory rules in contravention of his medical license."

That's on the May 31, 2018 grand jury transcript, pages 5 to 6.

In exchange for a plea agreement providing the possibility of a non-custodial probationary sentence, Hayek agreed to cooperate with the State. On April 1, 2016 Hayek participated in a proffer session with members of the Office of Insurance Prosecutors and during which he admitted that he had been receiving

cash payments directly from defendant for patient referrals since 2012. On April 8, 2016 Hayek was outfitted with a recording device while he attempted to discuss the kickback arrangements with defendant.

In exchange for being diverted into Pretrial Intervention and avoiding jail -- a jail sentence, Awari also agreed to cooperate with the State. On January 24, 2018 and February 7, 2018, as part of his cooperation, Awari participated in two proffer sessions with members of the Insurance Fraud Prosecutor's Office. During these sessions Awari admitted that he received between $2,000 and $3,000 in cash from the defendant for patient referrals between two -- 2012 and 2015.

On May 31, 2018 Detective Berg (phonetic) testified in front of the grand jury regarding both the statements of Hayek and Awari, as well as the recordings obtained in which defendant allegedly inculp -- inculpated himself by discussing the kickback schemes.

Defendant moved to dismiss Counts 2, 3, 4, and 8. As I explained at oral argument on May 13th, because the motion to dismiss Count 2 implicitly and necessarily includes a motion to dismiss the use of criminal runners' charge -- runners' charges, because

Count 2 is based, in part, on those charges, I'm also treating the motion to include a request for dismissal of Counts 6 and 10, which allege criminal use of runners. Because that aspect of the motion was not expressly set forth, the Court allowed the State an opportunity to submit an additional brief on the issue of the criminal use of runners following oral argument. In response to that offer and opportunity, I received nothing from the State. The State has not provided any authority at all to support the charges of criminal use of -- of runners that were included in the indictment.

A grand jury determines whether the State has established a prima facie case that a crime has been committed and that the accused committed it. That's <u>State versus Francis</u>, 191 <u>N.J.</u> 571 at 586 (2007). In seeking the indictment, the Prosecutor's sole evidential obligation is to present a prima facie case that the accused has committed a crime. <u>State versus Hogan</u>, 144 <u>N.J.</u> 216 at 236 (1996). In order to withstand the motion to dismiss, the State need only to present some -- some evidence as to each element of the charged offense. <u>State versus Vasky</u>, 218 <u>N.J. Super</u>. 487 at 491, Appellate Division (1987). The test of the sufficiency of an indictment is whether it contains elements of the offense intended to be charged and

gives the accused reasonable notice of the act or acts he's called upon to defend. State versus M.I., 253 N.J. Super. 13, at Page 19, Appellate Division (1991). A defendant who challenges an indictment must demonstrate that evidence is clearly lacking to support the charges. State versus Graham, 248 N.J. Super. 413, 4 -- at 417, Appellate Division (1995). In reviewing a motion to dismiss, the Court must consider the facts in the light most favorable to the State. State versus Saavedra, 433 N.J. Super. 501 at 514, Appellate Division (2013). An -- an indictment cannot stand, however, if it fails to charge a viable offense. State versus Bennett, 194 N.J. Super. 231, Appellate Division (1984), certification denied, 101 N.J. 224 (1985) State -- and State versus Wein, 80 N.J. 491 at 497 (1979). The trial court's discretion to dismiss an indictment should be exer -- not be exercised except upon the clearest and plainest grounds and unless it's palpably defective. State versus N.J. Trade Waste Association, 96 N.J. at 8 -- at 18 and 19 (1984). Accordingly, a trial court may dismiss an indictment only upon a palpable showing of fundamental unfairness -- unfairness. State versus Wein, 80 N.J. 5 -- at 501, or where the Prosecutor's conduct amounted to an intentional subversion of the grand jury process.

State versus Murphy, 110 N.J. 20 at 35 (1988). Dismissal of indictment is appropriate if it is established that -- that the violations substantially influence the grand jury's decision to indict or if there's grave doubt that the determination ultimately reached was arrived at fairly and impartially. State versus Hogan, 336 N.J. Super. 319 at 340, Appellate Division (2001).

Turning to Counts 3 and 8, healthcare claim fraud, pur -- N.J.S.A. 2C:21-4.2 states that healthcare claims fraud means making or causing to be made a false, fictitious, fraudulent, or misleading statement of material fact in, or omitting a material fact from, or causing a material fact to be omitted from any record, bill, claim, or other document that a person submits for payment or reimbursement for healthcare services.

The statute targets false or fraudulent claims. The State concedes that the claims at issue in this case were legitimate claims for necessary services provided by qualified providers to insured patients. There are no allegations of over-billing, over-prescribing, or fraud, or any type of fraud, other than the alleged payment of the referral fees. The claim submissions in this case were accurate and they

provided all of the information that was requested by the insurers on the universal health insurance claim form. There were -- was no false -- there were no false or fraudulent statements, and no information that was requested or necessary to submit the claim was omitted. There were no representations one way or the other regarding the payment of referral fees, because the insurers do not request that information on the health insurance claim form. The insurers didn't ask for a representation that referral fees were not paid as part of the claim submission process and defendant made no representations that could be construed to represent otherwise.

As the State told the grand jury, the claim against the defendant is premised on the notion that by submitting a health insurance claim form he omitted to tell the insurance companies that he was breaking an implied certification that he -- he, as a licensed doctor, was honoring his fiduciary duty to his patients not -- to not be paying kickbacks to other referring medical practitioners.

Where statutory language is clear and unambiguous, the Court must enforce it as written. Versus Moore, 358 N.J. Super. 241 at 247, Appellate Division (2003). Under the Rule of Lenity, however,

any ambiguity in criminal laws must be resolved in defendant's favor in order to afford the defendant fair notice that certain behavior is criminal. Individuals must receive fair warning that certain behavior is criminal. State versus Riley, 412 N.J. Super. 162, Appellate Division (2009).

In Riley, the court rejected the State's interpretation of a computer crime statute on the ground that it criminalized what amounted to a breach of an employment contract. Riley at 185. The State argued that criminal -- while incorporated by reference, informal and unclear workplace policies, but the Court found the State's interpretation did not provide sufficient notice to satisfy due process. Riley at 185 to 86.

Fair warning is fur -- is -- is -- is furthered by the void for vagueness doctrine in the United States versus Lanier, 520 U.S. 529 (1997). The void for vagueness doctrine requires that a penal statute define the criminal offense with sufficient definiteness that ordinary people can understand what conduct is prohibited and in a manner that does not encourage arbitrary and discriminatory enforcement, Kolender versus Lawson, 461 U.S. 352 in 1983. The touchstone is whether the statute, either standing

alone or as -- or as construed, made it reasonably clear at the relevant time that defendant's conduct was criminal. Lanier, 520 U.S. at 267. Although the doctrine focuses both on the actual notice to citizens and arbitrary enforcement, the more important aspect of the vagueness doctrine is not actual notice, but the other principal element of the doctrine, that is the requirement that our Legislature establish minimum guidelines to govern law enforcement. Smith versus Goguen, 415 U.S. 560 -- 66 at 574 (1974).

In this case, the -- the healthcare claims fraud statute criminalizes making a false, fictitious, fraudulent, or misleading statement of material fact and/or omitting a material fact from or causing a material fact to be omitted from any record, bill, claim, or other document that a person submits for payment or reimbursement for healthcare services.

As the State -- State explained to the grand jury, the defendant submitted the claims at issue using a universal health insurance claim form. That form, along with relevant patient records, were the only documents submitted for payment or reimbursement for health services. Defendant did not make any false, fictitious, fraudulent, or misleading statement of fact in any of those documents, nor did defendant omit any

fact, material or otherwise, from any of those documents. Defendant provided all of the information requested by the insurers on the health insurance claim forms. The State's attempting to shoehorn the use of referral fees into the statute by implicitly creating, from whole cloth, the requirement that providers include information regarding the payment of referral fees, a requirement that does not exist and a charge -- and then charging the defendant with omitting that information. One cannot -- cannot omit information from a claim form if that information is not sought in the first instance.

The State's contention that the H.C.C.F. statute extends to the defendant's alleged omission to tell the insurance companies that he was breaking an implied certification is a clear violation of the Rules of Lenity and fair warning. The Legislature did not include the payment of referral fees as an active healthcare claim fraud; of course, the Legislature could have done so, but it didn't. The State attempts to stretch the reach of the statute to include the payment of referral fees by contending that the failure to report the payment of such fees was an omission, but the insurers didn't ask for that information in the claim submission process and there's no reason why a

provider would be required to volunteer that information in the claim submission process. It was not requested or required by any applicable statute or regulation. The claim submission process focuses on the service provided and the patient who receives that service. There's no reason why the provider would have been required to provide information regarding the operation of the provider's business when submitting a claim for reimbursement.

The inferences set forth in 2C:40 -- 21-4.3(f)(1) and (2) provide context for the intended breach of the statute. Those inferences apply to failure to perform an assessment necessary to determine the appropriate course of treatment and in -- in other words, an unnecessary procedure, and submission of claims for more treatments or procedures than could have been performed during the time period; in other words, claims for services not actually provided.

There's no reason why information relating to referral fees would be required, it has nothing to do with the service provided to the patient for which the payment or reimbursement is being sought and for which the insurer is contractually obligated to pay or reimburse. At best, it's indirectly related to the service provided, because it relates to the business

practices of the pro -- provider. Because the information is not directly relevant or necessary to the claim submission process and because it's not information requested by the insurers as part of the claims submission process, there's no way to know it would be an active healthcare claim fraud to not volunteer that information regarding the payment of -- of referral fees in connection with the submission of the health insurance claim form. Therefore, it would violate the Rules of Lenity and fair warning to hold an individual criminally -- criminally responsible for the failure to volunteer information regarding referral -- referral fees in connection with the submission of the health insurance claim form.

The Legislature also could have included in the H.C.C.F. of this statute the type of implied certification requirement that the State is attempting to create. In fact, the Legislature did include such a provision in the <u>New Jersey Insurance Fraud Prevention Act</u>, <u>N.J.S.A.</u> 17:33(a)(1) through -- to (30). Under the <u>Insurance Fraud Prevention Act</u> it is a violation of the statute if a person,

"conceals or knowingly fails to disclose the occurrence of an event which affects person's initial or continued right or entitlement to any insurance

benefit or payment".

That's at 17:33(a)-4(a)(3).

The leg -- Legislature did not include any similar provision in the Criminal Healthcare Claims Fraud statute, rather the H.C.C.F. statute is limited to making false, fictitious, fraudulent, or misleading statements of fact in or omitting facts from documents submitted for payment or reimbursement for health services.

Based on the language of the Insurance Fraud Prevention Act, the Legislature knew how to include the type of implied certification language the State seek -- seeks to graft onto the H.C.C.F. statute, but have elected not to do so. The Legislature limited the scope of the H.C.C.F. statute to actual misrepresentations or omissions, it does not extend to the type of implied certification alleged in this case.

The State's reliance on Universal Health Services v. Escobar, 136 Supreme Court (1989), 2016 U.S. Lexus, 3920 2016 is misplaced. First, Escobar is a qui tam action under with the -- under the False Claims Act seeking civil penalties. It's not a criminal case.

Second, and more importantly, the Supreme Court did not adopt the extraordinarily broad implied

certification argument the State advances in this case, rather, the Court held the implied certification theory can be a basis of liability at least where two conditions are satisfied. First, that the claim does not merely request payment, but also makes specific representations about the goods or services provided and, second, that the defendant's failure to disclose noncompli -- or the defendant's failure to disclose noncompliance with a material statutory, regulatory, or con -- or contractual requirements makes those representations of a -- representations mis -- misleading half truths. That's Escobar at 136 Supreme at 2000. This would include, for example, using billing codes that in -- that indicated services were provided by qualified providers when those services were actually provided by unlicensed, uncreden -- uncredentialed or unqualified staff. The Court expressly -- the Supreme Court expressly did not resolve whether all claims for payment implicitly represent that a billing party is legally entitled to payment. Escobar at 136, Supreme Court at 2001.

In this case, the State can't point to any representations made in any health insurance claim form that is rendered misleading -- a misleading half truth by the failure to disclose the payment of referral

fees. Therefore, even if the implied certification theory adopted in Escobar applied to this criminal prosecution, which it does not, the State cannot satisfy the Escobar standard under the facts of this case. Based on the clear and unambiguous language of the H. -- H.C.C.F. statute, defendant did not commit an act of healthcare claim fraud. As a matter of law, the State cannot establish the defendant made any false, fictitious, fraudulent, or misleading statement of fact in any document submitted for payment or reimbursement for health services or that defendant admitted any fact, material or otherwise, from any such documents. Defendant, therefore, has met its burden to demonstrate the evidence is clearly lacking support in the charges. See State versus Graham, 248 N.J. Super. at 417. Even if the State could establish an omission as contemplated by the H.C.C.F. statute, which it cannot, the State cannot establish that the omission was material.

In State versus Goodwin, 224 N.J. 102 (2016) the Supreme Court held that statement -- a statement of fact is material if it could have reasonably affected the decision by an insurance company to provide insurance coverage to a claimant, or the decision to provide any benefit pursuant to an insurance policy, or

the decision to provide reimbursement, or the decision to pay a claim.

The State's effort to establish materiality before the grand jury was based on vague and ambiguous hearsay testimony. On this -- and this is at the -- in the grand jury transcript at Pages 71 and 72. The testimony included things such as the insurers -- the insurer said "some of them said a kickback scheme would definitely affect their investigation and payment of claims." Also, some were not willing to commit and say it definitely would and many of the insurer -- insurance companies considered the existence of a kick -- kickback scheme between providers to be material and the failure to disclose that scheme when billing is considered material to them, as well.

And the State didn't identify which of the insurers considered the payment of referral fees to be material or -- or what any of the insurers would have done if they knew about the payments. The best the State could do on materiality, therefore, was to tell the grand jury that some or many of the insurers would consider the existence of kickback schemes in their investigation of payment and payment of a claim.

The State needed to concede that some of the insurers would not even say -- they would not even say

the payment of re -- referral fees would be material to the investigation of payment of a -- on the payment of the claims, and the State didn't offer any testimony to support the claim that any of the insurers would have denied an otherwise legitimate and -- an insured claim based on the payment of a referral fee. It's not surprising, based on the facts of this case. Again, the medical procedures in this case were legitimate and necessary procedures performed by qualified professionals on insured patients. The insurers were obligated to pay the claims pursuant to the terms and conditions of the respective insurance policies with their insureds.

The State then took it one step further and told the grand jurors,

"Actually, there's substantial case law in civil context upon which many insurance companies re -- reply", I believe that's supposed to be rely, "wherein the Supreme Court has held that there is an implied certification whenever they are sending in these healthcare claim forms that medical providers have to comply with all significant statutes, such as the regulation in their -- in -- in their licenses".

This is, at best, a gross overstatement of the Supreme Court's decision in Escobar. In fact, as a

-- as I already discussed, Escobar says nothing of that sort. And, in fact, expressly does not adopt the legal analysis suggested by the State to the grand jurors here. It was extremely misleading to tell the grand jury that the United State Supreme Court issued a decision supporting the State's legal theory when that simply is not true.

At best, the evidence presented to the grand jury supports a finding that some of the insurers may have considered the payment of referral fees in their investigation in payment of claims. As the Supreme Court held in Escobar, it's not sufficient for a finding of materiality if the government would have had the option to decline to pay if it knew of the defendant's noncompliance. Escobar, 136 Supreme Court at 2003.

In the absence of evidence that the insurers or even some of the insurers would have actually declined coverage if they were aware of the referral payments, the State cannot establish the alleged omissions in the claim process were material.

Finally, the defendant provided evidence establishing that the insurers paid every claim submitted and continued to pay the claims without objection after the State obtained the superseding

indictment in this case. The State doesn't contest defendant's claims and has not provided evi -- any evidence to contradict it. The fact that the insurers continued to pay these claims after the superseding indictment was -- was -- was issued further undermines the State's claim of materiality.

As the Supreme Court noted in Escobar, if the government pays a particular claim in full, despite its actual knowledge that certain requirements were violated, that's very strong evidence that those requirements are not material. Escobar, 136 Supreme Court at 230 -- 2003 to 2004.

The insurers in this case continued to pay the very claims at issue after the defendant was indicted. This is strong evidence that the insurers did not view the payment of referral fees as material to their decisions to pay legitimate claims for medical services provided to their insureds.

In the end, defendant has demonstrated that -- that evidence is clearly lacking to support the charge of healthcare claim fraud alleged in Counts 3 and 8 of the superseding indictment. Because Counts 3 and 8 of the superseding indictment fail to charge a viable offense, they must be dismissed.

Now I'll move to the theft by deception --

theft by -- pursuant to 2C:20, and this is Count 4. Pursuant to 2C:20-4 a person is guilty of theft if he purposely obtains property of another by deception. A person deceives if he purposely a) creates or reinforces a false impression including false impressions as to law, value, intention, or other -- or other state of mind, b) prevent -- prevents another from acquiring information which would affect his judgment of a transaction, or, three -- or -- or c) fails to correct the false impression which the deceiver previously created or reinforced.

First, defendant did not obtain property of another as contemplated by 2C:20-4. The insurers paid and/or reimbursed amounts they were obligated to pay under the terms and conditions of their insurance policies with their insureds. Payments were made for legitimate claims for necessary medical services actually provided to their insureds.

The State claims -- the State's claim that the defendant committed theft because the insurers would have denied the claims if then insurers knew about the referral payments fails miserably. As discussed previously, the State did not provide any evidence that any of the insurance companies denied the claims on that basis. The best the insurer -- the

State could do was offer evidence that some of the insurance companies may have taken that fact into account in their investigation or payment of claims. Even if this -- this evidence established materiality for purposes of the Health Claims Fraud statute, which it does not, it would not support a claim of theft by deception.

Second, the State's implicit certification argument doesn't even come to close to establishing deception as contemplated by the theft by deception statute. In fact, the premises of the State's implicit certification argument is that the defendant did not make any false or misleading statements or omit any information requested by the insurers.

To prove theft by deception, the State must prove that defendant purposely created or reinforced a false impression or purposely prevented another from acquire -- acquiring information which would affect his or her judgment of a transaction or purposely failed to correct a false impression which the deceiver previously created or reinforced.

In this case, the State contends the defendant omitted information from the health insurance claim form that was not even sought by the insurers on the form. There's no evidence support a claim that

defendant purposely created or reinforced a false impression, purposely prevented the insurers from require -- from obtaining required information, or purposely failed to correct the false impression that defendant previously created or reinforced.

Third, the claim against the defendant arising out of his alleged taking of property from the insurer sounds in contract, not criminality. Distilled to its essence, the State contends that the insurers would have denied reimbursement for the claims because defendant violated the -- his various agreements with the insurers. Even if any of the insurers would actually have denied the claims, a claim that appears to be con -- contradicted by the fact that they did pay the claims, even after the defendant was indicted, the insurers would have based the denial on defendant's failure to comply with their agreements with the defendant. This type of breach of contract action has consistently been rejected as a basis for criminal charges. See State versus Bennett, 194 N.J. Super. 231, Appellate Division (1984) and State versus Riley, 412 N.J. Super. 162, that was Law Division (2009). Defendant's alleged breach -- defendant's alleged violations of his agreements with the various insurers is not a proper basis for a criminal charge of theft by

deception.

Finally, despite the fact that some identify -- some identified subset of the insurers would not even represent to the State that they would consider the payment of referral fees to be material information, much less that they would actually deny any -- any claims, the State aggregated all of the insurance payments made to all of the alleged re -- referral fee patients for purposes of establishing the second degree grading of the offense. There's no way for the grand jurors to determine the amount of the payments made by the insurers who refused to say they -- they would even consider the payments to be -- to be material to the decision to pay. It was improper for the State to present the aggregate amount of the insurance payments without reducing the amount for the insurers who would not even say that they might have declined the claims. The State knew that it could not establish that all of the insurers would have denied the claims, because all -- some of the insurers would not even tell them that they would consider this -- the -- the -- the fact in their -- in their investigation in payment of the claims, yet the State went ahead and told the grand jurors that all -- in effect, all of the insurers would have denied all of the claims when it

aggregated -- aggregated all of the amounts paid to Hayek and Awari in -- in -- in its presentation to the grand jury.

Again, the defendant has demonstrated that the evidence is clearly lacking to support the charge of second degree theft by deception alleged in Count 4 of the superseding indictment. Because Count 4 of the superseding indictment fails to charge a viable offense, it also must be dismissed.

Now with respect to criminal use of runners. This is 2C:21-22.1(b). A person is guilty of a crime if that person knowingly uses, solicits, hires, or employs another to act as a runner.

2C:21-22.1(c) provides that a runner means a person who, for pecuniary benefit, procures or attempts to procure a patient at the direction of, request, or -- or in cooperation with a provider with the purpose -- or in cooperation with a provider was -- whose purpose is to seek to obtain benefits under a contract of insurance.

The statute specifically provides runner shall not include a person who refers patients to a pro -- provider as otherwise authorized by law. In this case, the State concedes that but for the alleged payment of referral fees, Hayek and Awari were

authorized by law to refer patients to the defendant. In other words, as chiropractors, Hayek and Awari were authorized by law to refer patients to the defendant. The Legislature expressly excludes such persons, persons such as chiropractors, who are authorized by law to refer patients, but -- but to do so -- but who do so for a fee in violation of the applicable regulations and licensure requirements. For example, from the use of -- from the definition of runners, for purposes of the criminal use of runners statute. The State has not provided any authority to support its decision to charge the defendant under this statute and the Court's research doesn't reveal any. Again, I gave the State an opportunity to provide me anything that would support charging the defendant under this statute and the defen -- and the State provided me absolutely nothing, not a single piece of paper, not a single citation to anything that could possibly support charging the defendant under this statute, which by its plain -- plain reading he did not violate. In the absence of any authority that could possibly explain or justify the State's decision to charge the defendant with a violation of this statute, the State -- the State con -- this Court concludes that the State did so improperly based on a plain reading of the statute.

Because Hayek and Awari cannot qualify as runners under the statute, Counts 6 and 10 of the superseding indictment fail to charge a viable offense and also must be dismissed.

Count 2 of the superseding indictment alleges misconduct by a corporate official, contrary to 2C:21-9. Count 2 alleges that defendant used, controlled, or operated Interventional Spine Pain for the fur -- furtherance or promotion of 1) theft by deception, 2) healthcare claims fraud, and 3) criminal use of runners. Because all the offenses on which Count 2 is based have been dismissed, Count 2 also must be dismissed.

Finally, as I went through all of -- all of this analysis and I -- and I became more familiar with the -- with the legal concepts and -- and -- and fine -- and finer points of exactly what was charged and what was -- what was represented to the grand jury, this Court concludes that the State intentionally subverted the grand jury process resulting in a grand jury presentation that was fundamentally unfair. First, the State suggested to the grand jury that it should rely on or at least assuaged by the fact that there exists,

"substantial case law and civil context upon which many insurance companies rely, wherein the

Supreme Court has held that there is an implied certification whenever -- whenever they are sending in these healthcare claims forms, that medical providers have to comply with all significant statutes, such as the regulation in their licenses".

This was improper for two reasons. It was improper to suggest to the grand jurors that the -- that they should consider some ambiguously described body of law, including the alleged Supreme Court decision that allegedly supported the State's request for an indictment on the charges. This left the grand jurors not only with the impression that the legal instructions provided at the conclusion of the presentation should be considered in conjunction with some other vaguely defined body of law, but also that the State's legal position was supported by substantial case law and Supreme Court law.

In addition, the State's claim was misleading at best. In fact, the State should have told the grand jury that there is absolutely no law supporting the charges of healthcare claim fraud, use of criminal runners, or theft by deception. The State deceived the grand jury when it told them otherwise. Not a single one of the cases cited by the State is a criminal case and not a single one of those cases relates to the --

to the H.C.C.F. statute. Moreover, the State's apparent reference to the Supreme Court's decision in Escobar is flat out wrong. In addition to the fact that Escobar was a civil qui tam action, not a criminal case, the Supreme Court simply did not adopt the position represented by the State, instead, it adopted a test the State can't meet in this case. By incorrectly and misleadingly advisingly [sic] the grand -- advising the grand jury regarding the applicable law, the State left the grand jurors with the patently false impression that the law was in its favor. In fact, the State should have told the grand jury that there's absolutely no law that supported -- supported these charges. The State deceived the grand jury when it told them otherwise.

Second, the State charged the defendant with a violation of criminal use of runner statute even though it knew the claim failed as a matter of law. As explained previously, the Legislature expressly exempted from the definition of runner a person who refers patients to a provider as otherwise authorized by law.

As chiropractors, Hayek and Awari were authorized by law to refer patients to the defendant. The State was well aware that the Legislature expressly

excluded cases such as this from the reach of the criminal runner statute and the State cannot come with any -- come up with any authority to support its decision to charge the defendant in the face of the place language of the statute. In order to secure an indictment on this charge, the State failed to advise the grand jurors that -- what it plainly knew, that Hayek and Awari were authorized to refer patients to the defendant and could not qualify as runners. Instead, the State selectively -- selectively advised the grand jurors at the outset of the presentation that it would be prof -- professional misconduct for a chiropractor to receive referral -- a referral fee, and that's the transcript at Page 7. Yet it neglected to tell the grand jurors that they were authorized to refer patients to the defendant. By hiding the ball from the grand jurors and not advising them of the fact -- of a fact that was critical to the grand jurors' evaluation of the criminal runner statute, the State intentionally subverted the grand jury process.

In this case, in addition, as I -- as I mentioned earlier, despite knowing that the -- some -- at least some of the insurers, and we -- we have no idea how many of the insurers, told the State that they would not tell -- they would not consider the use of

runners as part of the investigation and -- and claim payment process, the State went ahead and aggregated all of the payments to -- with respect to all of the patients to all of the insurers in presenting the case to the grand jury, and -- and -- and as I said earlier, implicitly represented to the grand jury that all of those claims would have been denied; the State knew that was not true. The State absolutely knew that at least some of the insurers told them that they wouldn't even commit to considering it as part of the process, yet the State went ahead and -- and implicitly told the grand jurors that every single one of those claims would have been denied. That was clearly improper and it's simp -- simply cannot -- cannot be tolerated in the context of a presentation of charges like this to a grand jury.

In this case, the State lost sight of its obligation to do justice and instead sought to indict the defendant on the most serious charges it could present. Had the State not misled the grand jurors regarding the law applicable to the charges and had the State not charged defendant improperly with the use of criminal runners, and had the State not over -- overstated the materiality and misled the grand jury with respect to how -- how many, if any, of the

insurers would have actually denied the -- these claims, the Court is not convinced the grand jury would have indicted the defendant. In short, this Court has grave doubts that the determination ultimately re -- re -- reached was arrived at fairly and impartially.

Accordingly, Counts 2, 3, 4, 6, 8, and 10 of the superseding indictment are dismissed with prejudice. Counts 1, 5, 7, and 9 of the superseding indictment are dismissed without prejudice and, of course, the State is free to represent those charges to the grand jury in a fair and -- and appropriate manner, if it chooses to do so.

Okay. Thanks everybody.

MS. CALLAHAN: Thank you.

MR. WONG: Your Honor, is there a chance I can get a copy of that?

THE COURT: No. You can order a transcript.

MR. WONG: Oh, a transcript from your clerk?

THE COURT: Yes.

MR. WONG: Okay.

THE COURT: Oh, we can go off the record.

(END OF PROCEEDINGS)

CERTIFICATION

I, DOLORES S. HASTINGS, the assigned transcriber, do hereby certify the foregoing transcript of proceedings of May 23, 2019, digitally recorded, index number from 1:43:11 to 2:21:56, is prepared to the best of my ability and in full compliance with the current Transcript Format for Judicial Proceedings and is a true and accurate compressed transcript of the proceedings as recorded.

/s/ Dolores S. Hastings May 30, 2019

Dolores S. Hastings AD/T 417
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